Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

EL PASO SPECIALTY HOSPITAL
1755 CURIE DRIVE SUITE A
EL PASO TX 79902

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-03-8050-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We do not believe the reduction is justified. As you are likely aware, such provider reimbursement rates are typically adjusted based on the usual and customary treatment charges for that specialty and the geographical region where treatment was provided…the payment rendered does not appear to be comparable to rates charged for this service locally and no information has been given to support your position that the denial is correct." "Based on this information, we request the reductions be reversed and an additional payment be made."

Amount in Dispute: $13,478.60

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This carrier reimbursed the requester the surgical per diem for two days are required per the TWCC Rule 134.401. This carrier also reimbursed the requester the cost alleged by the invoices provided plus 10%." "It is this carrier's position the requester has not supported reimbursement in the amount billed, that the amount billed is due for the implants." "The requestor did not provide ANY cost information to justify reimbursement as billed."

Response Submitted by: Deborah Bailey, TMIC, 221 West 6th Street, Suite 300, Austin, TX 78749

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
January 15, 2003 through January 17, 2003	Inpatient Services	$13,478.60	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401, effective August 1, 1997, 22 TexReg 6264, sets out the reimbursement guidelines for inpatient hospital services.
3. This request for medical fee dispute resolution was received by the Division on June 25, 2003. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on July 3, 2003 to send additional documentation relevant to the fee dispute as set forth in the rule.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - F-Fee guideline MAR reduction.
   - TR-Reimbursed in accordance with the Texas hospital fee guideline.
   - YO-Reimbursement was reduced or denied after reconsideration of treatment/service billed.
   - YS-Supplemental payment.
   - S-Supplemental payment.
   - RD-The reimbursement for the service rendered has been determined to be fair and reasonable based on billing and payment research and is in accordance with Labor Code 413.011(B).
   - O-Denial after reconsideration.

Findings

1. 28 Texas Administrative Code §133.307(g)(3)(B), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including "a copy of any pertinent medical records." Review of the submitted documentation finds that the requestor has not provided copies of all medical records pertinent to the services in dispute. Although the requestor did submit a copy of the operative report, the requestor did not submit a copy of the anesthesia record, post-operative care record, or other pertinent medical records sufficient to support the services in dispute. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(B).
2. This dispute relates to inpatient medical services provided in a hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.401.
3. A review of the submitted hospital bill supports the primary services were surgical in nature; therefore, the Division finds that this is a surgical admission per 28 Texas Administrative Code §134.401(b)(1)(I).
4. 28 Texas Administrative Code §134.401(c)(1) states "Standard Per Diem Amount. The workers' compensation standard per diem amounts to be used in calculating the reimbursement for acute care inpatient services are as follows: Surgical $1,118."
5. The hospital admission was from January 15, 2003 through January 17, 2003; therefore, the length of stay was two days.
6. 28 Texas Administrative Code §134.401(c)(3)(B), the reimbursement calculation formula is "LOS X SPDA = WCRA."

   2 days multiplied by $1,118.00 = $2,236.00.
7. 28 Texas Administrative Code §134.401(c)(4), states "Additional reimbursement. All items listed in this paragraph shall be reimbursed in additional to the normal per diem based reimbursement system in accordance with the guidelines established by this section. Additional reimbursement apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section."
8. 28 Texas Administrative Code §134.401(c)(4)(A), states "When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278), and (ii) Orthotics and prosthetics (revenue code 274)."

   The Division finds that the requestor billed revenue code 278 for implantables at $7,558.90. The respondent paid $2,808.30 based upon "This carrier also reimbursed the requester the cost alleged by the invoices provided plus 10%." "It is this carrier's position the requester has not supported reimbursement in the amount billed, that the amount billed is due for the implants." "The requestor did not provide ANY cost information to justify reimbursement as billed."

   The Division finds that the requestor did not submit vendor cost invoices to support additional reimbursement for the implantables. No additional amount can be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	9/28/2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.